2020 Provider Fraud, Waste & Abuse Training

HIGHMARK. Delaware
HEALTH OPTIONS

OVERVIEW

- Overview of Payment Integrity (PI)
- Definitions & Types of Fraud, Waste & Abuse (FWA)
- Laws & Regulations
- Provider Responsibilities
- Resources

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HEALTH OPTIONS

MISSION

Highmark Mission:

To create a remarkable health experience, freeing people to be their best.

Payment Integrity Mission:

Protect our customers & lower the cost of healthcare by investigating instances of Fraud, Waste & Abuse (FWA) & recover overpayments.

Payment Integrity Strategy:

Utilize data analysis techniques to identify aberrant claims, perform claim coding reviews & conduct a variety of audits using investigative methods to assess the appropriateness of provider payments & pursue overpayment recoveries.

OVERVIEW OF PAYMENT INTEGRITY

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FUNCTIONAL AREAS

Investigation Team/SIU

- The Special Investigation Unit (SIU) team encompasses a Fraud Coordinator, Analysts, Senior Analysts & Consultant
- Investigates allegations of FWA
- Communicates with providers to recover overpayments
- Collaborates with other departments on best practices, process improvements & overpayments
- Create & submit referrals of suspected FWA to State & Federal agencies
- Execution of RFIs from our state partners as well as law enforcement agencies
- Maintain detailed case notes
- Streamline data reports to better serve all lines of business

Opportunity Team

- Comprised of multiple Certified Professional Coders
- Triage all FWA hotline calls & emails
- Review pertinent coding, using State & Federal guidelines
- Data mining activities to validate exposure, aberrant trends & schemes
- Provide overview write-up document for vetted allegations
- Provide additional support to Investigators through medical reviews

FUNCTIONAL AREAS

Vendor Team/ Reporting

- The Vendor team encompasses a Project Manager, Certified Coders & Financial Analysts
- Manages the relationship with our secured vendors to execute various Pre & Post Payment audits
- Complete all required monthly, quarterly, & annual distributions to the state timely & accurately
- Responds to Provider payment disputes
- Works with vendors for internal system updates

Education

- Coordinate educational opportunities from audits or investigations
- Conduct Provider trainings
- Provide internal trainings related to FWA
- Help close system gaps to prevent aberrant claims payments

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PAYMENT INTEGRITY FUNCTIONS

What we DO & why

- Prevent, detect & investigate alleged FWA referrals
- Identify & recoup inappropriate payments
- Responsibility to educate providers on what is required.
- Work with federal, state & local law enforcement agencies
- Believe in maintaining the integrity of services provided to Highmark Health Options members
- To ensure services are sustainable in the future

What we DON'T do

- Criminal investigations (Local, state, federal law enforcement)
- Complaints or Grievances
- Approve documentation templates
- Investigate provider related HIPAA concerns
- Licensing
- Investigate quality of care concerns

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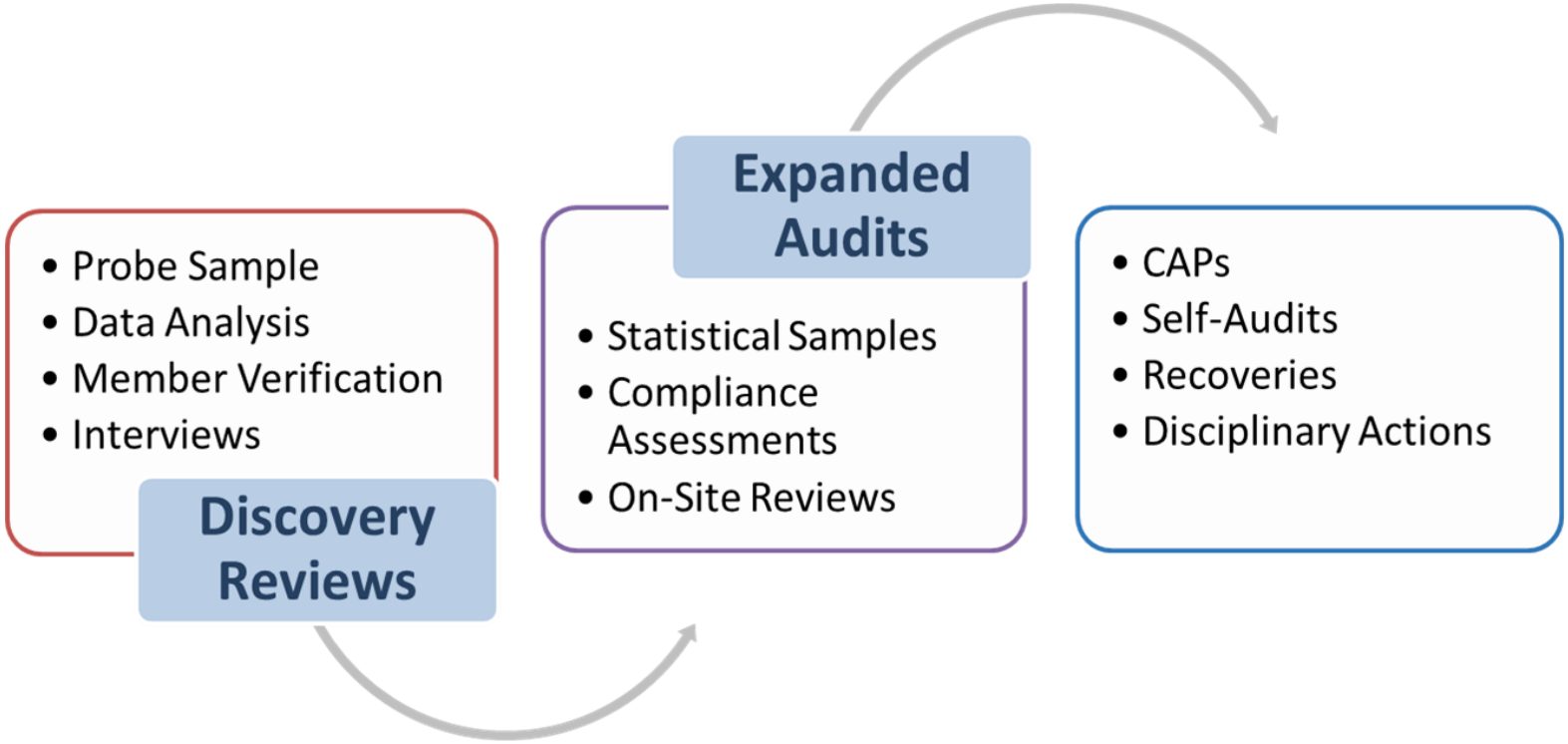
ROUTINE INVESTIGATIONS

Investigation of a reported allegation related to organizational activities for potential fraud, waste & abuse

- Data analysis
- Contract, licensure, policy review
- Member & provider verification
- Intra-Department collaboration
- Overpayment determinations
- Recoupment of overpaid dollars
- State & CMS referrals
- Local, State, & Federal law collaboration

PROGRESSIVE AUDIT



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REOCCURRING PROJECTS

A recovery project that reoccurs on a monthly, quarterly, or yearly basis in order to capture aberrant claim payments made

- Examples include the following:
  - Inability to systematically correct issue
  - Administrative or processor error
  - Complex calculations (i.e. Inpatient DRG)
  - Time based claim submission errors
  - System or member updates (i.e. Eligibility)
  - Required medical chart review
  - Diagnosis related reviews (i.e. Hospice)

REQUESTS FOR INFORMATION

What is an RFI?

- An incoming requests sent by regulatory or law enforcement agencies to Managed Care Organizations (MCO's) such as Highmark Health Options®. These requests require MCO's to pull specific information including, but not limited to, claims data, contracts etc.

Sources of RFIs

- MFCU – State Agency-Medicaid Fraud Control Unit
- SUR Unit – Fraud Referrals
- CMS – Center for Medicare & Medicaid Services
- OIG – Office of Inspector General of Health & Human Services
- Office of Inspector General Social Security Administration
- AG – Attorney General
- I-MEDIC
- Delaware Health & Social Services
- DMMA – Division of Medicaid & Medical Assistance
- FBI – Federal Bureau of Investigations

VENDOR ACTIVITIES

Contracted vendors of Highmark Health Options specializing in the following but not limited to:

- Ensuring payment accuracy
- Prepayment & post-payment claim reviews
- Inpatient & outpatient chart reviews
- Clinical validation
- Complex system edit set-ups
- Data mining trending healthcare patterns
- Contract compliance

RECOVERY OF OVERPAYMENTS

If any of the PI efforts identify overpayments, the following activities will occur:

- Highmark Health Options (“Health Options”) will comply with all Federal & State guidelines to identify overpayments;
- Health Options will pursue recoveries of overpayments through claims adjustments with recoveries by claims offsets or provider checks within 60 days;
- Health Options will refer suspected FWA to appropriate agencies, such as Medicaid oversight & CMS Medics; and
- Health Options may recommend corrective actions that may include pre-payment review, payment suspension & potential termination from Health Option’s provider network.

DEFINTIONS & TYPES: Fraud, Waste & Abuse

FRAUD

DEFINITION

- An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

EXAMPLES

- Knowingly billing for services not furnished or supplies not provided
- Billing for nonexistent prescriptions
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment

WASTE

DEFINITION

- Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs
- Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources

EXAMPLES

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive laboratory tests

ABUSE

DEFINITION

- Any practices that are inconsistent with sound fiscal, business, or medical practices, & result in unnecessary costs to the MA Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or contractual obligations for health care in a managed care setting

EXAMPLES

- Unknowingly billing for unnecessary medical services
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim, such as up-coding or unbundling codes

FEDERAL LAWS & REGULATIONS

FEDERAL LAWS & REGULATIONS

False Claims Act

- The False Claims Act (FCA) provides that any person who knowingly presents or causes to be presented a false or fraudulent claim for payment or approvals (among other activities) is liable to the United States Government for a civil penalty of $5,000 to $10,000 plus three times the amount of damages the Government sustains because of the act of that person.

- The FCA includes a *qui tam* provision, where individuals can bring claims on behalf of the Government in exchange for a percentage of any recovery.

See 31 United States Code (USC) Sections 3729–3733 for further information.

FEDERAL LAWS & REGULATIONS

Anti-Kickback Statute

- Provides civil & criminal penalties for individuals or entities that knowingly & willfully offer, pay, solicit or receive “remuneration” to induce the referral of business. Examples of “remuneration” include services (such as free testing or supplies) as well as items (such as cash, equipment, software, gifts, & other things of value)

- No bribes, kickbacks or other inappropriate payments should be offered or given to any person or entity for any reason including, but not limited to, the acquisition or retention of business

- Safe harbors may be applicable

See 42 United States Code § 1320a-7b for further information

FEDERAL LAWS & REGULATIONS

Stark Law

- The Stark Law prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has a financial relationship with that entity
- Claims tainted by an arrangement that does not comply with the Stark Statute are not payable
- Exceptions to the law may apply

See 42 United States Code §1395nn for further information

FEDERAL LAWS & REGULATIONS

Balanced Budget Act

- The BBA expanded the OIG's sanction authorities & established a toll-free fraud & abuse hotline for individuals who suspect that fraud or abuse have occurred in federal healthcare programs

- Further amendments to BBA were made in 2002 & require health plans to implement the following measures:
  - Document policies & procedures
  - Articulate a commitment to comply with state & federal regulations
  - Designate a compliance officer & compliance committee
  - Develop solid detection & reporting processes
  - Provide education to employees, providers, & members

See Public Law 105-33 for further information

FEDERAL LAWS & REGULATIONS

Deficit Reduction Act of 2005

- The Deficit Reduction Act of 2005 (“DRA”) established the Medicaid Integrity Program, the first comprehensive federal strategy to reduce fraud, waste & abuse in the Medicaid program

- Other examples of anti-fraud provisions enacted by the DRA include strengthening the ability of State Medicaid Agencies to pursue third-party liability, establishing a national expansion of the Medicare-Medicaid data match program, & including incentives for states to enact their own False Claims Act statutes

  See Public Law 109-171 for further information

FEDERAL LAWS & REGULATIONS

Fraud Enforcement Recovery Act of 2009

- The Fraud Enforcement Recovery Act of 2009 (FERA) made a number of changes to False Claims Act (FCA), including, but not limited to, broadening the range of conduct that can be subject to false claims prosecution, as well as updates to FCA filing procedures.

See Public Law 111-21 for further information.

FEDERAL LAWS & REGULATIONS

Patient Protection & Affordable Care Act

- In addition to providing funding to combat healthcare fraud, the Patient Protection & Affordable Care Act (ACA) enacted a number of provisions targeted toward the prevention of fraud, waste & abuse. Some of the notable components of the ACA include the following:
  - Established robust screening requirements for providers & suppliers;
  - Expanded the role of Recovery Audit Contractors to Medicaid & Medicare Parts C & D;
  - Required providers to develop a Compliance Plan; and
  - Revisions to the False Claims Act & Stark Law

FEDERAL LAWS & REGULATIONS

Patient Protection & Affordable Care Act (cont.)

- The ACA also adopted new penalties to deter fraud, waste & abuse, including, but not limited to:
  - Harsher civil & monetary penalties on providers who commit fraud;
  - Increasing the federal sentencing guidelines for health care fraud offenses involving more than $1,000,000 in losses; and
  - New fines & penalties for providers who fail to return overpayments from Medicare in Medicaid within 60 days

See Public Law 111-148 for further information

FEDERAL LAWS & REGULATIONS

21st Century Cures Act

- The 21st Century Cures Act enacted a number of changes to strengthen fraud & abuse measures in the Medicaid program. Some of the notable changes include the following:
- Requiring states to screen & enroll providers participating in a Medicaid or CHIP managed care organization who are not already enrolled in the state's fee-for-service program
- Requiring states to submit information regarding terminated Medicaid & CHIP providers to a centralized database
- Prohibiting federal financial participation for items & services delivered by terminated providers; and
- Establishing a timeline for states to adopt electronic verification systems for certain Medicaid-provided services, including personal care & home health services.

See Public Law 114-255 for further information.

STATE LAWS & REGULATIONS

STATE LAWS & REGULATIONS

Healthcare Fraud

- A person is guilty of health care fraud when the person knowingly:
  - (1) Presents or causes to be presented any fraudulent health care claim to any health care benefit program; or
  - (2) Engages in a pattern of presenting or causing to be presented fraudulent health care claims to any health care benefit program.
- "Fraudulent health care claim" is any statement, written, oral or in any form, which is made as part of or in support of a claim or request for payment & contains false, incomplete, or misleading information concerning any fact or thing material to the claim.
- "Health care benefit program" is any plan or contract, whether public or private, under which any service is provided. It includes any individual or entity who is providing a medical benefit or service for which payment may be made under a plan or contract for the provision of such benefit or services.

See 11 DE Code § 913A for more information.

STATE LAWS & REGULATIONS

Theft

- A person is guilty of theft when the person takes, exercises control over or obtains property of another person intending to deprive that person of it or appropriate it
- Theft is a class G felony
- If the value is more than $50,000 but less than $100,000 it is a Class D felony
- If the value is more than $100,000 it is a Class B felony

See 11 DE Code § 841 for further information.

STATE LAWS & REGULATIONS

Falsifying Business Records

- (a) For purposes of this section, “medical record” means a record that pertains to a person's medical history, evaluations, tests, diagnoses, prognoses, laboratory reports, medical imaging, treatments, prescriptions, or any other information used in assessing a person's physical, mental, or emotional condition
- (b) a person is guilty of falsifying business records when, with intent to defraud, the person:
  - (1) makes of causes a false entry in the business records of an enterprise
  - (5) Alters or modifies, or causes the alteration or modification of the medical record of any person; or
  - (6) Created or causes to be created any false medical record

- Falsification of Business Records is a Class A Misdemeanor

See 11 DE Code § 871 for further information.

STATE LAWS & REGULATIONS

Abuse, Neglect, Exploitation or Mistreatment of an Impaired Adult

- (a) Any person who knowingly or recklessly abuses, neglects, exploits or mistreats an adult who is impaired shall be guilty of a Class A misdemeanor
- (c) Any person who knowingly or recklessly abuses, neglects, exploits or mistreats an adult who is impaired, & causes bodily harm, permanent disfigurement or permanent disability shall be guilty of a class D felony
- Where the abuse, mistreatment or neglect results in death, such person shall be guilty of a class A felony

See 31 DE Code § 3913 for further information.

STATE LAWS & REGULATIONS

Abuse, Neglect, Exploitation or Mistreatment of an Impaired Adult (cont.)

- 31 Del. C. § 3902(2) "'Adult who is impaired' shall mean any person 18 years of age or over who, because of physical or mental disability, is substantially impaired in the ability to provide adequately for the person's own care & custody"
- 11 Del. C. § 231- "Recklessly" A person acts recklessly with respect to an element of an offense when the person is aware of & consciously disregards a substantial & unjustifiable risk that the element exists or will result from the conduct. The risk must be of such a nature & degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation

STATE LAWS & REGULATIONS

False Claims & Reporting Act

- (a) Any person who:
  - (1) Knowingly presents, or causes to be presented a false or fraudulent claim for payment or approval;
  - (2) Knowingly makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim;
  - (3) Conspires to commit a violation of paragraph (a)(1), (2), (4), (5), (6) or (7) of this section;
- Shall be liable to the Government for a civil penalty of not less than $10,957 & not more than $21,916, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 2015 (28 U.S.C. § 2461, note), for each act constituting a violation of this section, plus 3 times the amount of damages which the Government sustains because of the act of that person

See 6 DE Code § 1201 for further information

PROVIDER RESPONSIBILITIES

COMPLIANCE PLAN

- Providers are required to establish a compliance program that prevents & detects FWA as a condition of enrollment in the Medicare & Medicaid programs
- The Office of Inspector General provides the following eight guidelines for providers in creating their compliance programs:
  - Conduct internal monitoring & auditing;
  - Implement compliance & practice standards;
  - Designate a compliance officer or contact;
  - Conduct appropriate training & education;
  - Respond appropriately to detected offenses & develop corrective action;
  - Develop open lines of communication with employees;
  - Enforce disciplinary standards through well-publicized guidelines; and
  - Compliance programs must be effective.
- All providers are required to have compliance plans, no matter the size of your practice
  - OIG Guidance for Compliance Program for Individual & Small Group Physician Practices

PROVIDER SELF-AUDIT

- Providers are required to conduct self-audits to identify documentation errors & potential overpayments
- Federal & state laws & regulations require overpayments to be returned within 60 days of identification
- Providers can submit overpayments to Highmark Health Options by using the Provider Self-Audit Overpayment form found on our website
- Resources for Self-Audits:
  - OIG Guidance

MEDICAL NECESSITY – DELAWARE CODE

"Medically Necessary" or “Medical Necessity"

- Providing of health-care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms in a manner that is all of the following:
  - In accordance with generally accepted standards of medical practice;
  - Consistent with the symptoms or treatment of the condition;
  - Not solely for anyone's convenience; and
  - Not including investigational or experimental health-care services

See 18 DE Code § 3371 for further information.

MINIMUM DOCUMENTATION – DELAWARE REQUIREMENTS

The Board of Medical Licensure & Discipline requires providers to properly maintain patient records

- 17.13 Patient Record Violations
  - Patient records consist of documentation that reflects the physician-patient relationship & any misuse of the documentation constitutes a patient records violation.
  - Failure to adequately maintain patient records includes, but is not limited to, misconduct such as the failure to adequately document evaluation and/or treatment of the patient, failure to adequately maintain or store the records, & failure to allow the patient or the patient's authorized representative access to the records.

See 24 DE ADC 1700 for further information.

MINIMUM DOCUMENTATION – HHO PROVIDER MANUAL

Basic guidelines for medical records

- Providers are responsible for following all requirements under Federal & State regulations, publications, & bulletins that are pertinent to the treatment & services provided.
- Providers should follow the medical record standards as defined in Medicaid contracts, Medicare manuals, provider contracts, provider manuals, & all regulations.
- Providers must have member records that include all Medicaid and/or Medicare requirements, are individual & kept secure.
- Providers are responsible for obtaining the appropriate order, referral, or recommendation for service.
- All documentation must meet the requirements of the service codes that are submitted on the claims form.
- All progress notes & billing forms must be completed after the session.
- All documentation & medical record requirements must be legible.
- All amendments or changes to the documentation must be signed & dated by the clinician amending or changing the documentation.
- All requirements for documentation must be completed prior to the claim form submission date.

MINIMUM DOCUMENTATION – HHO PROVIDER MANUAL (cont.)

Highmark Health Options sets forth the following documentation standards regarding medical records for all providers

- Must contain the minimum personal biographical data: DOB, Gender, Address, Home Telephone Number, Employer, Occupation, Work Telephone Number, Marital Status, Name of Next of Kin, Next of Kin Telephone Number
- Allergies & Adverse Reactions
- Significant illnesses & medical conditions
- Laboratory & other studies ordered
- Medical history, such as family history, psychosocial history, medical-surgical history, baseline physicals, & periodic updates
- High risk behaviors (Tobacco/cigarette, alcohol, substance abuse, HIV/STD, nutrition, social & emotional risks, etc.)
- Continuity of care is documented
- Immunizations & dates
- Must be easy to read & legible

CONSENT TO TREATMENT – DELAWARE REQUIREMENTS

The Board of Medical Licensure & Discipline has established certain requirements regarding patient informed consent

- 17.14.14 Failure to obtain consent is considered an aggravating factor by the Board when making a determination regarding provider discipline
- 18.3 sets forth specific requirements regarding informed consent for providers prescribing controlled substances for the treatment of pain
  - Must discuss risk & benefits with patient or individual with decision-making capacity

CONSENT TO TREATMENT – HHO PROVIDER MANUAL

Highmark Health Options sets forth the following documentation standards for consent to treatment for all providers

- Valid for dates of service
- Identifies the patient
- Signed & dated by the patient
- Signed, dated & credentialed by the clinician
- List types of services and/or treatments
- Includes the benefits & potential risks
- Includes alternative services and/or treatments
- Must be easy to read & legible

RELEASE OF INFORMATION FOR PAYMENT – HHO PROVIDER MANUAL

Highmark Health Options sets forth the following documentation standards regarding releases of information for payment for all providers

- Valid for dates of service
- Identifies the patient
- Signed & dated by the patient
- Signed, dated & credentialed by the clinician
- List the types of services and/or treatments
- Must be easy to read & legible

PRIVACY PRACTICES – FEDERAL REGULATIONS

The Privacy Rule of the Health Insurance Portability & Accountability Act (HIPPA) requires covered entities to distribute a notice of their privacy practices to patients with respect to their protected health information

- The Notice of Privacy Practices must include the following:
  - Information regarding uses & disclosures of PHI
  - Patient's individual rights
  - Provider's duties
  - Complaints
  - Contact Information

- See 45 CFR § 164.520 for further information.

PRIVACY PRACTICES – HHO PROVIDER MANUAL

Highmark Health Options sets forth the following documentation standards regarding privacy practices for all providers

- Valid for dates of service
- Identifies the patient
- Signed & dated by the patient
- Signed, dated & credentialed by the author/clinician
- Must be easy to read & legible

TREATMENT PLAN – DELAWARE REQUIREMENTS

The Board of Medical Licensure & Discipline requires providers to properly document the evaluation & treatment of their patients

- 17.13 Patient Record Violations
  - Failure to adequately maintain patient records includes, but is not limited to, misconduct such as the failure to adequately document evaluation and/or treatment of the patient
- 18.2 specific requirements for the treatment of pain
  - Goals & objectives
  - Whether further diagnostic tests or evaluations are planned
  - The extent to which pain is due to physical or psychosocial impairment

See 24 DE ADC 1700 for further information.

TREATMENT PLAN – HHO PROVIDER MANUAL

Highmark Health Options sets forth the following documentation standards regarding treatment plans for all providers

- Valid for dates of service
- Identifies the patient
- Signed & dated by clinician (witness or author's identification)
- Documents that member or guardian reviewed or participated with the development of the treatment plan
- Identifies the diagnosis
- Identifies interventions & goals of treatment
- Document necessity for treatment
- Reviews are completed timely as applicable
- Must be easy to read & legible

MEDICATION LIST – HHO PROVIDER MANUAL

Highmark Health Options sets forth the following documentation standards regarding medication lists for all providers

- Medication prescribed
- Signed & dated by clinical
- Lists dosages, dates & refills
- References the side effects & symptoms
- Must be easy to read & legible

UNPROFESSIONAL CONDUCT

UNPROFESSIONAL CONDUCT – DELAWARE

24 DE Code § 1731 Unprofessional conduct & inability to practice medicine

- The Delaware Code details that providers may be disciplined by the Board of Medical Licensure & Discipline for certain “unprofessional conduct.”
- As defined in the Code, “unprofessional conduct” can include:
  - (b)(1) The use of any false, fraudulent, or forged statement or document or the use of any fraudulent, deceitful, dishonest, or unethical practice in connection . . . with the practice of medicine
  - (b)(3) Any dishonorable, unethical, or other conduct likely to deceive, defraud, or harm the public

UNPROFESSIONAL CONDUCT – DELAWARE (cont.)

24 DE ADC 1700 Dishonorable or Unethical Conduct

- 8.1 The phrase "dishonorable or unethical conduct likely to deceive, defraud, or harm the public" as used in 24 DE Code 1731(b)(3) shall include, but not be limited to, the following specific acts:
  - 8.1.1 A pattern of performance of unnecessary medical procedures.
  - 8.1.4 Fraudulent billing for medical services.
  - 8.1.5 Intentional falsification of records maintained for controlled substances & non-controlled drugs.
  - 8.1.13 Failure to adequately maintain & properly document patient records.

See 24 DE ADC 1700 for further information.

RESOURCES

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HHO RESOURCES

- Medicaid Resources
  - Forms & Reference Materials
  - Procedure Codes
  - Provider Contracts
  - EPSDT
- HHO Provider Manual
- HHO Fraud & Abuse Website

DELAWARE RESOURCES

- Delaware Health & Social Services
- Division of Medicaid & Medical Assistance
- Delaware Medical Assistance Portal
- Delaware Medicaid Fraud Control Unit

FEDERAL RESOURCES

- CMS Fraud & Abuse Website
- CMS Self-Audit Snapshot
- OIG Provider Self-Disclosure Protocol